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FORMAL COMPLAINT

Documented HIPAA, Medicaid, Mental Health Parity, and Retaliation Violations With Evidence of State Oversight Failure

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Submitted To:

- **U.S. Department of Health and Human Services – Office of Inspector General**
- **U.S. Department of Health and Human Services – Office for Civil Rights**
- **Centers for Medicare & Medicaid Services (CMS)** – Center for Medicaid & CHIP Services, Center for Program Integrity
- **U.S. Department of Justice – Healthcare Fraud Unit & Midwest Strike Force**
- **Federal Bureau of Investigation – Healthcare Fraud, Public Corruption, Civil Rights, Cyber, and White-Collar Crime Units**
- **Government Accountability Office (GAO)**
- **Federal Trade Commission (FTC)** – Fraud Complaint Division
- **U.S. Office of Special Counsel**
- **Members of the Congressional Mental Health Caucus**
- **Members of the House Committee on Oversight and Reform**
- **Members of the Senate Committee on Homeland Security and Governmental Affairs**
- **Members of the House Committee on Energy and Commerce, Subcommittee on Health**
- **Members of the Senate Finance, Subcommittee on Health**
- **Members of the Senate Committee on Health, Education, Labor, and Pensions**
- **Medicaid and CHIP Payment and Access Commission (MACPAC)**
- **Illinois Office of Executive Inspector General**
- **Illinois Department of Healthcare and Family Services – Office of Inspector General**
- **Illinois Office of the Auditor General**

Submitted By:

[redacted]

Date of Submission: 14 August 2025

Executive Summary & Urgency Statement

This is not speculation, clerical error, or regulatory confusion. It is a fully documented account of **more than 50 violations** of federal and state law committed by **Molina Healthcare of Illinois** and its delegate **Optum** (a UnitedHealth Group subsidiary), with the **Illinois Department of Healthcare and Family Services (HFS)** knowingly refusing to enforce mandatory oversight obligations.

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Violations include:

- **HIPAA Privacy and Security breaches** — unlawful PHI demands without proper authorization, no minimum necessary justification, and no valid BAA with our practice.
- **Medicaid violations** — prepayment reviews without credible evidence of fraud, violation of payment timeliness laws, and discriminatory utilization management.
- **Mental Health Parity Act violations** — applying stricter standards to behavioral health than medical services.
- **Retaliation** — termination of our behavioral health contract **68 minutes** after filing a federal HIPAA complaint.
- **State oversight failure** — HFS closed the case without investigation, citing false information, and ignored clear federal oversight mandates.

This is not a routine provider dispute. It is **regulatory sabotage** that undermines HIPAA protections, Medicaid access, mental health parity, and whistleblower safeguards. It has directly harmed patients, disrupted continuity of care for vulnerable populations, and mismanaged taxpayer funds.

I am calling for **immediate federal investigation and enforcement action**. The enclosed evidence package cites every controlling statute, regulation, and case law violated, provides timelines, documentation, and names the responsible parties. If this conduct and state-level complicity is allowed to stand, it sets a dangerous precedent that corporate contractors can operate above the law so long as regulators look the other way.

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Exhibit – At-a-Glance Violations Chart

Category	Citation(s)	Violation Summary
HIPAA – Business Associate Agreement (BAA) Requirements	45 C.F.R. § 164.502(e); 45 C.F.R. § 164.504(e)	Molina directed PHI be sent to Optum without a valid BAA between our practice and Optum.
HIPAA – Minimum Necessary Standard	45 C.F.R. § 164.514(d); 45 C.F.R. § 164.506(d)(5)	Optum demanded full medical records for single claims without justification; excessive scope.
Medicaid – Improper Delegation	42 C.F.R. § 438.230(b)	Improper delegation of Medicaid functions to Optum without oversight/control.
HIPAA – Unauthorized PHI Disclosure	45 C.F.R. § 164.508(a)(2)(i)(A), (4), (b), (c)	PHI requested without valid patient authorization for purposes unrelated to direct treatment/payment.
HIPAA Security Rule – Safeguards	45 C.F.R. § 164.306; 45 C.F.R. § 164.308	PHI sent to affiliates with breach history (Change Healthcare, Episource).
HIPAA – Anti-Retaliation	45 C.F.R. § 160.316	Termination 68 minutes after HIPAA complaint filed.
HIPAA – Breach Logging	45 C.F.R. § 164.530(j)	Failure to log/report systemic PHI disclosures and breaches.
False Claims Act – Whistleblower Protection	31 U.S.C. § 3730(h)	Retaliation after reporting suspected fraud/waste.
HIPAA – Anti-Retaliation (Statutory)	42 U.S.C. § 1320d–5(d)	Prohibits retaliation for filing HIPAA complaints.
HITECH Act – Whistleblower Protection	HITECH Act § 13410(d)	Prohibits retaliation against those reporting HIPAA violations.
Medicaid – Network Adequacy	42 C.F.R. §§ 438.206, 438.207	No continuity of care plan or replacement providers after termination.
Medicaid – Continuity of Care	42 C.F.R. §§ 438.208(c)(4), 438.62(a)	Failure to coordinate patient transitions during provider removal.
Medicaid – Enrollee Rights	42 C.F.R. § 438.10(d); 42 C.F.R. § 438.100	Failure to ensure nondiscrimination and access.

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Medicaid – Oversight & Program Integrity	42 C.F.R. § 438.230; 42 C.F.R. § 438.608	Failure to oversee subcontractors and ensure lawful PHI handling.
Medicaid – Provider Nondiscrimination	42 C.F.R. § 438.214	Unlawful deselection following protected activity.
Medicaid – Patient Choice	42 C.F.R. § 438.52	Removing provider choice in psychiatric care.
Medicaid – Special Populations Access	42 C.F.R. § 438.206(b)(4)	Failure to meet needs of special populations (SMI patients).
Medicaid – Adequacy Standards	42 C.F.R. § 438.3(l)	Breach of network adequacy requirements.
Illinois Medicaid – Access Standards	89 Ill. Admin. Code § 140.491(d–e)	Network fails CMS time/distance standards.
Illinois Insurance – Payment Timeliness	215 ILCS 5/368a	Late clean claim payments; no statutory interest.
Illinois Medicaid – Prepayment Review Rules	305 ILCS 5/12-4.25(k); 89 Ill. Admin. Code § 140.44	Prepayment reviews without credible fraud evidence or due process.
Medicaid – Fraud, Waste, Abuse Standards	42 C.F.R. § 455.2; 42 C.F.R. § 455.20; 42 C.F.R. § 455.23	Prepayment review without credible fraud allegations; no reporting to oversight bodies.
Medicaid – Provider Protections	42 C.F.R. § 455.17	Coercive audit/record requests without legal basis.
Medicaid – Parity Protections (MHPAEA)	29 U.S.C. § 1185a; 29 C.F.R. § 2590.712(d)(4); 45 C.F.R. § 146.136(c)(4); 42 C.F.R. § 438.910	Stricter standards for behavioral health vs. medical services.
PHS Act – Provider Non-Discrimination	42 U.S.C. § 300gg–5(a)	Discrimination based on specialty/license type.
ACA – Nondiscrimination	ACA § 1557; 42 U.S.C. § 18116	Discrimination and retaliation in health program.
Medicaid – Sanctions Authority	42 C.F.R. § 438.710(b)	Misconduct meets threshold for federal/state sanctions.
Illinois Medicaid Oversight	305 ILCS 5/5-30.1; 305 ILCS 5/5-30.2(b)	Failure to investigate provider complaints and enforce MCO contract compliance.

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14 August 2025

Members of the Congressional Mental Health Caucus
U.S. House of Representatives
Washington, D.C. 20515

RE: URGENT – Request for Federal Investigation: Molina Healthcare of Illinois & Illinois Department of Healthcare and Family Services – Over 50 Violations Involving Healthcare Fraud, Public Corruption, HIPAA Breaches, Retaliation, and Medicaid Program Abuse

Dear Members of the Congressional Mental Health Caucus,

What if I told you one of the nation's largest Medicaid contractors committed over 50 violations of federal and state law and the agency meant to hold them accountable stood by and did nothing, but looked the other way? This isn't red tape confusion. It's regulatory sabotage.

This is not speculation. This is not a clerical oversight. This is a documented, systemic breakdown of regulatory compliance, willful negligence, and retaliation carried out by Molina Healthcare of Illinois, and tacitly endorsed by the Illinois Department of Healthcare and Family Services (HFS).

Violations span HIPAA, Medicaid payment laws, mental health parity, provider non-discrimination, improper record requests, and consideration for exercising federal whistleblower protections. And despite being fully informed, Illinois HFS chose silence over enforcement. This is not a misunderstanding. This is willful complicity.

This isn't just one bad actor. This is a regulatory failure and a betrayal of the trust placed in these institutions to protect providers, patients/insured consumers, and mismanagement of state funds. If this is allowed to stand, it sets a chilling precedent: that corporate insurers can break the law with impunity so long as the state looks the other way.

I urge you, no, I challenge you to read what follows because if something is not done this is not just a Molina problem; it becomes a national one. Congressional oversight is not only warranted; it's overdue. Because if this can happen here, it can and will happen anywhere again and again.

We respectfully submit this formal complaint regarding Molina Healthcare of Illinois and its contracted delegate, Optum (a UnitedHealth Group subsidiary), for repeated, egregious violations of HIPAA, data privacy regulations, and improper record access and disclosures. The pattern of misconduct raises serious questions about regulatory compliance, PHI safeguarding, and retaliatory behavior toward providers lawfully exercising their rights.

The retaliation, after resisting this improper request, is a double violation for unlawful request and retaliating when I raised the concerns and exercised protected rights to maintain HIPAA

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regulated compliance requirements to safeguard my patient's medical records containing sensitive PHI.

Secondly, Optum on behalf of Molina calls, "Prepayment Review" to verify coding and documentation of services billed is actually a Non-Compliant PHI request lacking legal authority. A prepayment review in Illinois Medicaid requires credible evidence of fraud or abuse. Molina's letter admits the review is *not* based on medical necessity and gives no indication of suspected fraud, which is the only lawful justification under Medicaid law for a prepayment hold. If no audit findings or formal allegations preceded this, it's an illegal fishing expedition and violates 42 C.F.R. § 455.23 and § 455.20. This "review" was issued after we were instructed to stop contacting the CEO which clearly shows temporal proximity and retaliatory motive. This qualifies as an Unlawful, Non-HIPAA-Compliant, Medicaid-Violating, Retaliatory Pretextual Review Designed to Chill Provider Speech and Force Improper Disclosure of sensitive PHI Without Legal Authority or Safeguards.

Even though Optum is acting "on behalf of Molina," that does not override HIPAA mandates. Optum is the requesting entity and not directly involved in patient care. Optum does not qualify as a "Covered Entity." As HIPAA requires, 1) the entity must have a relationship with the patient, 2) the PHI that is shared or disclosed must be relevant to the relationship between the covered entity and the patient, and 3) when sharing PHI, the covered entity must only disclose the minimum necessary information for the purpose of the qualifying disclosure. As this request originates from a third-party entity engaged by Molina for its own administrative purposes, and not from a party directly involved in our treatment, payment, or healthcare operations, any exchange of protected health information must be evaluated for and handled meeting compliance with applicable privacy regulations, minimum necessary, and other applicable compliance structure.

[redacted] is a covered entity under HIPAA and not a subcontractor to Molina or Optum. Molina alleges Optum is their Business Associate, that may be true, however facts support that only permits Optum to receive PHI from Molina, not from anyone else without providing an appropriate signed authorization by the patient meeting HIPAA's mandates as defined under HIPAA mandates. Our obligations as a covered entity are separate and not permitted to rely on another covered entity's BAA to justify a PHI disclosure and to protect against anticipated impermissible uses or disclosures that are not allowed by the rule. If we disclose records improperly, even at the request of a payer, we are the party who faces the potential risk for HIPAA penalties, not Optum or Molina. Molina's internal agreements with Optum do not override legal obligation as a Covered Entity to protect the patient's Protected Health Information (PHI) in accordance with HIPAA regulations.

Furthermore, the regulations highlight Molina's significant and consistent violations.

1. Improper Disclosure of PHI Without Valid Business Associate Agreement (BAA)
   - *45 C.F.R. § 164.502(e)* and *45 C.F.R. § 164.504(e)* require a covered entity to execute a valid Business Associate Agreement before disclosing Protected Health Information

(PHI) to any third party. Despite repeated demands, Molina directed us to submit patient records to Optum, a delegate for prepayment review purposes, without providing evidence of any BAA executed between our practice ([redacted]) and Optum.

- Delegation of PHI access to Optum without such agreement constitutes a direct violation of HIPAA and places our practice at serious liability risk.

2. Violation of Minimum Necessary Rule and Improper Scope of Request
   - *45 C.F.R. § 164.514(d)* and *45 C.F.R. § 164.506(d)(5)* prohibit covered entities from requesting entire medical records unless specifically justified as necessary. Optum on behalf of Molina demanded full records from our practice for several patients without demonstrating the necessity for full chart disclosure. No risk adjustment justification or clinical audit notice was provided. Furthermore, HIPAA requires minimum necessary standard requesting an entire medical record for a single code is excessive unless clearly justified, which they did not do.
   - *42 CFR § 438.230(b)* further prohibits improper delegation of Medicaid functions without oversight and control. Molina's failure to supervise Optum's blanket record demands without regulatory basis represents systemic noncompliance.

3. Unauthorized Use and Disclosure Without Valid Authorization
   - *45 C.F.R. § 164.508(a)(2)(i)(A) and (4), (b) and (c)* specifies that any use or disclosure of PHI not related to treatment, payment, or operations requires explicit patient authorization. Molina, through Optum, demanded psychiatric records for prepayment review without any evidence of such authorization, and for purposes unrelated to direct treatment or payment for a specific service.
   - These demands appear to serve internal fraud, waste, and abuse screening or actuarial functions, none of which qualify for exemption without proper consent.

4. Data Security Risks from Delegated Agents With Breach History
   - *45 C.F.R. § 164.306* and *§ 164.308* outline HIPAA's Security Rule obligations, including appropriate technical and administrative safeguards.
   - Molina's demand that records be sent to Optum is particularly troubling in light of the massive data breaches linked to Change Healthcare and Episource, both entities under UnitedHealth Group ownership.
   - Directing sensitive mental health records to affiliated entities with known breach events fails to meet required standards of care and undermines patient privacy.

5. Retaliation for HIPAA Complaint Activity
   - *45 C.F.R. § 160.316* explicitly prohibits retaliation against individuals or entities who file HIPAA complaints or report compliance concerns. Following our formal complaints about PHI access, Molina issued a "without cause" contract termination, selectively cutting off only our behavioral health division.
   - HIPAA prohibits intimidation, threats, coercion, discrimination, or retaliation against any person for filing a complaint, participating in an investigation, or opposing violations.

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- This pattern of behavior clearly suggests retaliatory motivation after protected activity under HIPAA, especially no documented quality issue or contract breach especially after informing Molina of filing a HIPAA complaint and was served 68 minutes later with a contract termination. This is temporal proximity so tight it screams retaliation. The "no-cause" clause excuse does NOT override federal anti-retaliation laws.
- We are a protected party under HIPAA, and retaliation is illegal regardless of contractual language.
- The "no-cause" clause does not shield a plan from liability especially when it is used as a pretext for unlawful retaliation and such termination interferes with public policy meaning compliance with federal law, and termination is in bad faith or chilling protected activity.
    - *Nesselrotte v. Allegheny Energy, Inc.*, 615 F. Supp. 2d 397 (W.D. Pa. 2009): Temporal proximity alone (hours/days) can establish retaliation.
    - *Perry v. Sindermann*, 408 U.S. 593 (1972): Even without a formal contract, government actions that chill constitutional or statutory rights are subject to scrutiny.

6. Failure to Log and Report Systemic Disclosures and Breach Risks
    - *45 C.F.R. § 164.530(j)* mandates that covered entities log all PHI disclosures and report improper disclosures as breaches when systemic.
    - If Molina and Optum made such unauthorized requests of multiple providers without proper agreements or justifications, this constitutes a widespread, reportable breach event.

7. Federal Protection Against Retaliation
    - *31 U.S.C. § 3730(h)* under the False Claims Act protects individuals and entities who lawfully report fraud, waste, and abuse from retaliation. The subsequent actions taken by Molina, including contract termination and disruption of care to vulnerable Medicaid members, reflect retaliatory measures fall under federal whistleblower retaliation protections.

The retaliatory nature of Molina Healthcare of Illinois' actions following protected whistleblower activity represents a serious breach of federal law. Specifically, after [redacted] submitted a formal HIPAA complaint on March 28, 2025, regarding unlawful prepayment medical record requests by Optum (a third party lacking a valid Business Associate Agreement with our practice) or signed authorizations by the patient meeting HIPAA requirements as defined under Title 164.508(4)(c). Documented evidence supports, Molina rather than meeting HIPAA compliance requirements, issued a contract termination notice just 68 minutes later. Such acts by Molina are retaliatory in nature.

Whistleblower & Retaliation Protections exist for a reason and Molina continues to be in direct violation of federal law. This constitutes a direct violation of:

- 42 U.S.C. § 1320d–5(d) – Prohibits any covered entity or business associate from retaliating against an individual or entity for filing a HIPAA complaint with the U.S. Department of Health and Human Services (HHS).
- 31 U.S.C. § 3730(h) – Provides whistleblower protections under the Federal False Claims Act, specifically forbidding discrimination, harassment, suspension, or termination of a contractor or provider for efforts to stop violations of federal law, including fraud or misuse of public funds. Contract termination immediately following protected activity constitutes presumptive retaliation.
- HITECH Act § 13410(d) – Expands HIPAA enforcement and includes OSHA-like whistleblower protections for those reporting violations. Terminating a provider in response to a good faith complaint is precisely the type of misconduct the HITECH Act was intended to prevent.

To date, no prior performance issues, fraud allegations, or complaints were raised against our behavioral health practice. Our contract was unilaterally terminated without cause following our efforts to hold Molina accountable for repeated noncompliance with HIPAA and Medicaid claims handling and reimbursement requirements. This retaliatory action was not only unlawful, but it was also chilling, clearly intended to discourage regulatory reporting and shield systemic violations from scrutiny.

Molina Healthcare of Illinois' termination of our behavioral health contract without cause, notice of deficiencies, or replacement providers has created widespread disruption in access to care for Medicaid recipients seeking mental health treatment particularly vulnerable populations with complex psychiatric needs. This conduct violates both federal Medicaid managed care regulations and the Illinois Medicaid Managed Care Model Contract and demonstrates a systemic failure to maintain required network adequacy.

Under 42 C.F.R. §§ 438.206 and 438.207, Managed Care Organizations (MCOs) are required to maintain a sufficient and stable network of providers, including behavioral health services, to ensure access to covered services. Molina's abrupt removal of our practice from its behavioral health panel without any documented plan for replacement or transition of care directly violates this obligation. The issue is compounded by evidence that no other local psychiatric providers are available within required geographic or timeliness standards, as confirmed by multiple patient complaints and referral breakdowns.

Federal regulations require continuity of care in the event of provider transitions. As stated in 42 C.F.R. § 438.208(c)(4) and § 438.62(a), both MCOs and states must implement mechanisms to coordinate ongoing care during changes to provider networks. Molina has done none of this instead, they instructed patients to contact out-of-network or non-existent behavioral health providers, which constitutes a clear breach of care continuity and enrollee protections. Furthermore, the Illinois Medicaid Managed Care Model Contract (2023–2025), § 5.20.1.2 mandates that MCOs must assist enrollees in selecting new providers and coordinate care transitions following provider terminations. Molina failed to do this and instead requested that

we, the now out-of-network practice coordinate referrals despite having no contractual authority to do so post-termination.

By intentionally terminating a psychiatric provider without cause, disrupting ongoing care relationships, and offering no legitimate replacement option, Molina has undermined and interfered with the enrollees' protected rights to both timely access and continuity of care.

Molina has violated nearly a dozen state and federal Medicaid regulations, creating systemic access barriers, undermining patient care by interfering and violations that qualifies as breaching both the letter and spirit of managed care obligations.

Molina violated 42 C.F.R. § 438.10(d) and § 438.100, which guarantee Medicaid enrollees:

- Clear, accurate, and accessible information about network providers
- The right to access services without discrimination or unreasonable barriers
- Services delivered with respect to privacy and ethical standards

The misconduct further violates:

- 42 C.F.R. § 438.230 – MCOs must oversee and ensure delivery of Medicaid services in compliance with contractual and programmatic standards. Removing a high-volume behavioral health provider in retaliation for regulatory complaints demonstrates failure to maintain oversight and program integrity.
- 42 C.F.R. § 438.214 – MCOs are prohibited from discriminating against providers who serve high-risk or underserved populations. Termination following protected regulatory reporting activity is not a lawful basis for provider deselection and violates federal standards.
- 42 C.F.R. § 438.52 – Enrollees must have meaningful choice among qualified providers. Molina's removal of our behavioral health services in a region with limited psychiatric access violates this right and diminishes patient choice.
- 42 C.F.R. § 438.206(b)(4) – MCOs must address cultural competency and the needs of special populations. Abruptly eliminating an established psychiatric provider with no replacement plan for patients with severe mental illness is a direct violation of these access and population sensitivity obligations.
- 42 C.F.R. § 438.207 – Requires that Medicaid services are sufficient in amount, duration, and scope to meet patient needs. Cutting off psychiatric care mid-treatment without continuity, justification, or patient recourse is inconsistent with this federal requirement.
- 42 C.F.R. § 438.3(l) – State contracts must enforce network adequacy and require MCOs to maintain access. A no-cause termination that severs essential behavioral health services constitutes breach of contract and regulatory dereliction.
- 89 Ill. Admin. Code § 140.491(d–e) requires timely access and a sufficient number of behavioral health providers within defined geographic regions. Molina's current network falls far short of this requirement and fails to meet CMS time and distance access standards.

Molina Healthcare of Illinois has also repeatedly failed to adhere to state statutes and federal billing standards governing Medicaid claims handling and payment timelines, prepayment review practices, and coding accuracy resulting in improper denials, delayed reimbursements, and coerced record disclosures.

Under 215 ILCS 5/368a, Illinois law mandates that clean claims be paid within 30 calendar days for electronic submissions. When claims are not paid within this statutory window, the payer is required to remit interest at the rate of 9% per annum on the delayed payment. Molina has consistently violated this regulated requirement, with numerous clean claims either unpaid or reimbursed months late without explanation and without the statutorily mandated interest payment. These payment failures represent not only breach of contract but also statutory noncompliance and expose Molina to enforcement action which has yet to transpire.

Additionally, Molina's prepayment claims review, executed via Optum (a third-party business affiliate of UnitedHealth Group), lacked the legal basis required for such action. Under 305 ILCS 5/12-4.25(k) and 89 Ill. Admin. Code § 140.44, prepayment withholds, or reviews must be supported by credible allegations of fraud, waste, or abuse, and must follow due process protocols. At no point was our practice ever notified of any credible fraud allegation or under investigation nor were we afforded any due process rights. Instead, Molina unilaterally initiated broad prepayment reviews with no regulatory justification, demanding patient records in clear violation of both HIPAA standards and Illinois administrative code.

If Molina's request was truly legitimate, Molina would not have paid the claims in question. Their payment of what they cited of good faith is far from that as they knew their acts to intentionally delay benefits due the Medicaid recipient's impacted by this deceptive behavior, was against state and federal regulations. These organizations abuse and bank on smaller practices who typically lack a significant amount of resources, being ignorant to the rules which they are then able to intentionally take significant advantage of these providers rendering mental health services in good faith.

This abuse of the prepayment review process appears not only abusive and retaliatory but also operationally inconsistent: Molina never conducted prepayment reviews on our medical services contract, further underscoring that the behavioral health reviews were discriminatory and punitive, rather than compliance-driven.

Lastly, Molina has repeatedly misapplied the National Correct Coding Initiative (NCCI) edits by bundling services improperly when different providers operating under separate taxonomies and NPIs rendered services on the same day. According to CMS guidance, services provided in separate sessions or by different providers are not to be bundled. These errors directly reduce provider reimbursement and are in clear violation of federal billing standards and guidelines, undermining the integrity of Medicaid claims handling processes.

Together, these actions demonstrate a systemic disregard for state and federal Medicaid billing regulations, abuse of compliance tools for retaliatory purposes, and flagrant noncompliance with

proper claims adjudication protocols. These violations merit proper oversight, regulatory enforcement, audit, and civil penalties under Illinois law and federal oversight.

Molina Healthcare's invocation of fraud, waste, and abuse (FWA) as justification for its prepayment record reviews and post hoc contract termination represents not only a misuse of federal and state regulatory frameworks but also supports evidence of a likely retaliatory and fraudulent cover-up in violation of multiple federal statutes.

Under 42 C.F.R. § 455.2, fraud, waste, and abuse have clear federal definitions and threshold requirements. Before any prepayment review or audit is initiated under the guise of FWA, MCOs are required to meet procedural safeguards and minimum evidence standards.

Per 42 C.F.R. § 455.23, any credible allegation of fraud must be reported promptly to the appropriate oversight agency. Molina has never issued any notification of findings or alleged misconduct against our practice. No notice of investigation was issued, no allegations were substantiated, and no audit results were presented therefore, any prepayment review conducted by Optum lacked a legal foundation and violated due process rights.

Further, 42 C.F.R. § 455.20 requires that MCOs follow proper notice and review procedures for provider investigations. Molina intentionally bypassed this regulated requirement entirely. Violation of these procedural obligations renders their FWA justification legally invalid and administratively suspect.

The Federal False Claims Act (31 U.S.C. §§ 3729–3733) prohibits the knowing misuse or mishandling of state and federal funds, including in Medicaid programs. Terminating a provider after they report HIPAA violations, refuse to unlawfully disclose PHI, or question improper reviews of Medicaid claims constitutes retaliatory action protected under FCA § 3730(h). FCA § 3730(h): "Any employee, contractor, or agent shall be entitled to all relief necessary to make them whole if they are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against… because of lawful acts done… in furtherance of an action under this section."

As the provider of service, we acted to prevent what I reasonably believed to be fraudulent or noncompliant behavior involving misuse or mishandling of Medicaid funds and unlawful PHI disclosure. In return, Molina retaliated via contract termination without cause, due process, or justification shortly after HIPAA and compliance complaints were submitted.

This is classic False Claims Act retaliation and also implicates Medicaid fraud reporting obligations. Further, changing the justification for a prepayment review from routine audit to "fraud/waste concerns" after you escalated HIPAA issues is strong evidence of pretextual reasoning, which speaks to intent or knowledge both required elements under FCA.

Pursuant to 42 C.F.R. § 438.608, Medicaid MCOs must establish internal controls and conduct oversight of fraud prevention activities including ensuring that contracted third parties (like Optum) do not exceed delegated authority or engage in unlawful practices.

Molina violated this rule by:

- Delegating audit authority to Optum without ensuring a legal or contractual basis
- Failing to monitor Optum's practices, including large-scale PHI requests with no BAA between the provider and Optum and without meeting patient authorization regulated requirements.
- Misrepresenting to state agencies the nature and purpose of the reviews to evade regulatory scrutiny.

In addition, 42 C.F.R. § 455.17 protects providers from coercive audits or record reviews. Molina's demand for entire medical records absent evidence, legal justification, or BAA violates federal audit safeguards and exposes both Molina and Optum to sanctions for coercive conduct and HIPAA violations.

Under Illinois Medicaid policy (305 ILCS 5/12-4.25(K) and 89 Ill. Adm. Code § 140.44), prepayment review can only be initiated based on evidence resulting from a preliminary audit that suggests fraud or overutilization. "The Department shall only impose prepayment reviews upon credible findings of fraud, waste, abuse, or medically unnecessary services, following a preliminary audit and written notice."

Molina's letter, however, failed to meet the following requirements:

- Provide valid audit results
- Cite a statutory basis for FWA
- Failed to notify the state or federal oversight bodies of any fraud allegation, as required under § 455.23.

This is not merely an error. It is a systematic misuse of regulatory authority to manipulate and silence a provider whistleblower and avoid accountability.

Molina Healthcare's termination of our behavioral health contract while simultaneously maintaining our medical contract represents a textbook violation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations under the Public Health Service Act and the Affordable Care Act.

Non-Quantitative Treatment Limitations (NQTLs) Violated:

- 29 U.S.C. § 1185a / 29 C.F.R. § 2590.712(d)(4)
- 45 C.F.R. § 146.136(c)(4)
- CMS FAQ Set 45 (2023)
- 42 C.F.R. § 438.910

Under these federal rules, health plans including Medicaid Managed Care Organizations (MCOs) are prohibited from applying non-quantitative treatment limitations (NQTLs) to mental health or substance use disorder (MH/SUD) benefits more stringently than to medical/surgical benefits in the same classification.

NQTLs include:

- Admission and retention criteria for provider networks
- Credentialing, reimbursement rate negotiation, and termination policies
- Utilization management and prepayment review protocols

29 C.F.R. § 2590.712(d)(4)(i) specifically includes: "Standards for provider admission to participate in a network, including reimbursement rates." Molina's decision to terminate only our behavioral health contract, while keeping our medical contract active, demonstrates clear disparate treatment and a violation of MHPAEA and HIPAA mandates.

This selective action was:

- Not based on quality of care or credentialing.
- Not part of a global termination or restructuring and
- Occurred shortly after a HIPAA and regulatory complaint was filed.

This is precisely the kind of behavior that NQTL regulations were written to prevent.

Processes and Standards Must Be Comparable which is noted in 29 C.F.R. § 2590.712(d)(4)(ii): "A group health plan may not impose a nonquantitative treatment limitation... unless the processes, strategies, evidentiary standards, or other factors used... are comparable to, and are applied no more stringently than, those used for medical/surgical benefits." No such stringent standard was applied to our medical contract. The only discernible difference is our identification of HIPAA violations and refusal to disclose PHI without a valid BAA and required patient authorization that include required disclosure protections, specifically within the behavioral health division.

Thus, if Molina claims this termination is linked to documentation, review, or payment concerns, they are using NQTLs in a manner more stringent for behavioral health than for medical/surgical benefits.

This is a federal parity violation, enforceable by the U.S. Department of Labor, HHS, CMS, and state insurance regulators.

PHS Act § 2706(a): Provider Non-Discrimination under 42 U.S.C. § 300gg–5(a) identifies, "A group health plan and a health insurance issuer... shall not discriminate with respect to participation... against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

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Molina's actions also implicate provider discrimination. By terminating only our behavioral health contract while retaining our primary care practice we believe Molina has:

1. Discriminated based on provider specialty (psychiatric vs. medical);
2. Applied differential treatment based on license type (PMHNP vs. FNP); and
3. Retaliated against a mental health provider for refusing to engage in Molina's non-compliant PHI disclosure requests and for escalating compliance issues.

This violates federal provider non-discrimination protections under the Public Health Service Act (PHS). This discrimination is especially egregious given that our services were within full scope of license, state law, and credentialing with no quality concerns raised prior to the contract termination.

The Consolidated Appropriations Act (CAA) of 2021 mandates disclosure requirements that all health plans are required to adhere and maintain, as well as requirements to provide upon request, a comparative analysis of NQTLs, including:

- Credentialing
- Provider admission/termination standards
- Reimbursement practices
- Utilization management

We request that the Department of Labor, CMS, and state regulators immediately obtain and review Molina's NQTL comparative analysis in this case. It is highly unlikely Molina can demonstrate parity compliance in light of:

- Our preserved medical contract vs. terminated psychiatric contract
- The retaliatory timeline post-HIPAA complaint
- Disparate treatment of behavioral health services in reimbursement, review, and enforcement.

It is important to also note that as an attempt to seek compliance assistance from the Illinois Department of Healthcare and Family Services (HFS) to investigate and address violations associated with Molina's improper acts, State-Level Medicaid Oversight Obligations were non-existent. Despite repeated escalations and documentation of Molina Healthcare's noncompliance, the Illinois Department of Healthcare and Family Services (HFS) has failed to fulfill its statutory and regulatory duties to oversee its Medicaid Managed Care Organization (MCO) contractors. This abdication of oversight is not just bureaucratic neglect, it contributes to and encourages systemic fraud, waste, and abuse that results in endangering and defrauding vulnerable Medicaid enrollees especially with Federal Oversight Mandates 42 C.F.R. § 438.66 & § 438.602(b), "States must ensure ongoing monitoring of each MCO's operations… including compliance with requirements for access, availability, and quality of care."

CMS State Medicaid Director Letters reinforce that state Medicaid agencies bear the full legal responsibility for ensuring MCO compliance even when duties are delegated according to 42 C.F.R. Part 441, Subparts B, D, G, and H. Establish additional requirements for behavioral

health services, care coordination, and access for special populations (e.g., those with mental illness).

Violation:

- Despite documented parity violations, wrongful terminations, HIPAA complaints, and clear network adequacy failures by Molina, HFS has repeatedly responded with dismissiveness, telling providers to "work it out with the MCO" a response that is not only inappropriate but contrary to federal regulations and state oversight obligations.

Illinois Medicaid Statutes and Administrative Code exist which clearly was not followed or upheld.

- 305 ILCS 5/5-30.1 – Oversight of Medicaid Managed Care, "The Department shall exercise rigorous oversight of managed care organizations... and shall ensure contract compliance with respect to continuity of care and access to services."
- 305 ILCS 5/5-30.2(b) – Public Complaints, "The Department shall investigate complaints from providers and beneficiaries and take corrective action when plans violate their contractual or regulatory obligations."
- 89 Ill. Admin. Code § 140.491(e), "The Department shall ensure MCOs maintain adequate provider networks and meet time/distance access requirements for behavioral health."

Violation:

- HFS was notified of Molina's wrongful contract termination, prepayment review misuse, and selective enforcement targeting behavioral health services, yet it refused to intervene or investigate the matter, citing that both parties had "legal teams" involved. [redacted] did not have any type of legal parties involved. Utilized false statements to close a case and refuse to adhere to regulations.
- This "hands-off" approach violates both federal Medicaid oversight rules and the Department's own state-level duties under 305 ILCS and 89 Ill. Admin. Code.

Failure to Enforce State Medicaid Contract with The Illinois Medicaid Managed Care Model Contract (2023–2025) which Molina is bound by contains numerous provisions requiring:

- Network adequacy maintenance
- Continuity of care during provider transitions
- Oversight of subcontractors (e.g., Optum)
- Timely and accurate provider reimbursement
- Access to care for special populations

By refusing to enforce these provisions, HFS has not only enabled Molina's misconduct, but it has also arguably become an accessory to the ongoing harm inflicted upon providers and enrollees alike. Every federal and state employee takes an oath to serve its role in accordance with applicable guidelines and in full compliance of governing laws. Illinois state employees swear an oath to uphold the United States and Illinois Constitutions and faithfully discharge their duties. The oath signifies commitment to public service and adherence to the laws and principles

of the state and the nation. Apparently where Illinois Healthcare and Family Services is concerned, this is a selectively applied when it's not convenient and benefited to uphold the law. Quite honestly if no person shall be deprived of liberty or property without due process of law nor be denied the equal protection of the laws; is this a selective process to protect large businesses that time and time again violate federal and state laws?

Furthermore, Contract Law & Good Faith Obligations were not evident. Molina Healthcare's conduct toward our practice especially in terminating only our behavioral health contract while retaining our medical contract, following our HIPAA-related whistleblower complaint represents a violation of fundamental legal principles of contract law, including bad faith, pretextual retaliation, and violations of program integrity.

Implied Duty of Good Faith and Fair Dealing which is not evident either. Illinois Common Law: Every contract contains an implied duty of good faith and fair dealing. This principle is especially important in healthcare contracts where public policy and patient care are implicated.

Relevant Case Law:

- *Perry v. Sindermann*, 408 U.S. 593 (1972) – Even in the absence of formal protections, governmental actors (or contractors paid with public funds) may not retaliate in ways that chill constitutional or statutory rights.
- *Nesselrotte v. Allegheny Energy, Inc.*, 615 F. Supp. 2d 397 (W.D. Pa. 2009) – Temporal proximity between protected activity (e.g., a HIPAA complaint) and termination creates a strong presumption of retaliation.

Violation:

- Molina exercised a "no-cause" termination clause as a pretext for retaliation, after we raised legal objections regarding HIPAA and PHI disclosure demands.
- "No-cause" does not mean no-consequences when used to suppress regulatory complaints or interfere with access to care.
- Retaliatory timing undermines the contract's integrity and creates legal exposure for violating public policy and insured consumer protections.

CMS & Medicaid Integrity Program Requirements 42 C.F.R. § 438.608(a)(5–8) is that Medicaid MCOs must implement procedures that ensure program integrity, provider due process, and non-discriminatory contracting practices.

Violation:

- Molina's termination targeted a provider actively engaged in HIPAA compliance reporting, which is antithetical to CMS program integrity expectations.
- This violates the required internal controls and fair treatment of providers as established under federal law.

Documented evidence on file supports Fiduciary-Like Obligations of Medicaid MCOs is notably absent. While Medicaid is not governed by ERISA, managed care organizations receive and disburse taxpayer funds and therefore must operate in a manner analogous to fiduciaries:

- They must act in the best interest of enrollees.
- They must not act arbitrarily or capriciously in a way that disrupts care, mismanages state funds, or squanders public dollars.

Violation:

- Molina's selective termination of behavioral health services, under a pretextual no-cause clause and with no clear replacement plan, is inconsistent with fiduciary principles and contributes to waste, inefficiency, and more importantly, patient harm.

Section 1557 of the Affordable Care Act (ACA) 42 U.S.C. § 18116 (ACA § 1557) Prohibits discrimination in health programs or activities receiving federal financial assistance.

Violation:

- Molina's decision to terminate only mental health services, in proximity to a HIPAA complaint, constitutes discrimination in care delivery and retaliation for protected legal conduct.
- Further, mental health parity and provider-type discrimination issues (e.g., against PMHNPs) raise additional concerns under Section 1557 and PHS Act § 2706.

Sanctions & Enforcement 42 C.F.R. § 438.710(b)

States and CMS may impose sanctions for:

- Failure to ensure access, nondiscrimination, or availability of services.
- Misconduct affecting provider relationships or service delivery.

Violation:

- The combination of retaliatory termination, misuse of PHI, pretextual or fabricated audits, and disrupted behavioral health access meets the threshold for state and federal sanctions.

Medicaid Provider Due Process Violations under both Illinois law and federal Medicaid regulations, an MCO cannot:

- Deny claims or terminate providers based on unregulated internal policies (e.g., vague or undisclosed prepayment review triggers),
- Impose non-statutory audit criteria that conflict with HIPAA or parity laws, or
- Withhold payments without credible fraud evidence or due process under 305 ILCS 5/12-4.25(K) and 89 Ill. Admin. Code § 140.44.

Violation:

- Molina's shifting justifications (from vague audits to pretextual prepayment review) appear designed to evade legal scrutiny rather than uphold integrity.

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- These actions violate basic due process rights, especially where Medicaid funds and vulnerable populations are involved.

This begs the question again of the lack of regulatory compliance from Illinois Healthcare and Family Services. Significant evidence was provided, but yet and still closed the case citing, "*HFS is aware of [redacted]'s complaint and similar emails have been sent to the HFS Medicaid Administrator and Director. Both Molina's legal team and [redacted]'s legal team are engaged in the issues presented in this complaint and taking the necessary actions to resolve, therefor HFS is not getting involved and this ticket can be closed."* Upon receipt of such it was disputed, and it was made abundantly clear that, "No attorney is representing [redacted], [redacted], in this dispute, and no correspondence submitted by our office ever suggested otherwise. Therefore, HFS's rationale for dismissing our complaint on the grounds that "legal teams are engaged and working to resolve the matter" is not only inaccurate but demonstrates a concerning degree of procedural negligence. One might reasonably expect that, before closing a regulatory complaint, someone would at least verify whether the central justification for closure was true and accurate."

This is extremely alarming as a regulatory agency tasked with monitoring the conduct of Medicaid Managed Care Organizations (MCOs), HFS, should not be in the business of dismissing serious allegations of acts supporting the potential for fraud, waste, and abuse, or for noncompliance based on false assumptions. This action or rather, inaction sends a deeply troubling message: that a managed care plan can retaliate against a provider who filed a HIPAA complaint, disrupt patient care, and violate its contractual obligations without consequence, so long as someone at HFS mistakenly checks a box that says, "legal teams involved."

We are urging immediate federal intervention. Given the persistent inaction, dismissive responses, and failure by Illinois HFS to uphold its regulatory obligations and in consideration of harmed Medicaid enrollees impacted by Molina's inappropriate acts, we respectfully request action taken immediately and without delay.

We request a formal investigation into HFS's oversight failures pursuant to 42 C.F.R. § 438.66, including its tacit approval of HIPAA violations, mental health parity noncompliance, retaliatory conduct, and network adequacy breakdowns.

Further, we ask that CMS issue a Corrective Action Plan (CAP) requiring Illinois HFS to immediately address its failure to enforce critical federal consumer protections involving HIPAA, parity standards, and Medicaid access.

Every day this misconduct is allowed to persist, patients are harmed and defrauded, providers are silenced, and public funds are mismanaged and misused. To prevent further harm to consumers insured under Molina, now is the time for accountability, transparency, and decisive federal oversight and compliance assistance.

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Insurance companies bank on practices being too uninformed, too short-staffed, or too overwhelmed to recognize when legal lines are crossed. They rely on fear, exhaustion, and complacency to get away with violations and far too often, it works.

What they fail to understand is that my military service taught me perseverance, discipline, and how to fight battles worth fighting. This is one of those battles.

If you believe I will be intimidated, worn down, or distracted into compliance, you are gravely mistaken. I am not the one. I will not be silenced, I will not be ignored, and I will not stop until every violation is exposed and every accountable party is held to the full measure of the law.

Sincerely,

Crystal Stone, PMHNP-BC, FNP-BC, CPMA, CPC, CPB

cc: HHS-OIG, HHS OCR, CMS, GAO, MACPAC, Department of Justice, Congressional Mental Health Caucus, House Committee on Oversight and Reform, Senate Committee on Homeland Security and Governmental Affairs, House Committee on Energy and Commerce - Subcommittee on Health, Senate Finance Subcommittee on Health Care, Senate Committee on Health, Education, Labor, and Pensions